Welcome to the ICD-10 Summit!

It’s a privilege to spend the next two days with such an outstanding group of individuals focused on the important work of making our healthcare system better.

We believe ICD-10 will be an important stepping-stone to becoming more precise in healthcare, giving us a more accurate picture of what care we deliver, as well as the associated cost. We see tremendous benefit in using the more granular information for tracking, benchmarking and improvements.

The transition will be difficult, and probably already is for most of you. It’s a monumental task, and we are betting on monumental change as a result. Our goal for the Summit is to make it easier.

The idea for the Summit was sparked by conversations with customers who expressed frustration about not having a place to really learn from their peers about ICD-10 transition. While many conferences focus only on the payer or provider perspective, very few (if any) focus on both. We felt it important to adopt a “we’re all in this together” approach to the Summit, thus focusing on all perspectives.

This Summit is about you. It’s been designed with you in mind, and the agenda was heavily influenced by what you said you wanted to learn and know. As a result, we’re confident you will get the information you need to accelerate your efforts and ease the burden. We’ve lined up an incredible group of speakers who will be sharing lessons learned and best practices. We thank them for taking the time to share their stories and expertise with all of us.

Edifecs is delighted to be your host. We have a team of people here to help make this event worth your time and attention. Please let us know how we can best serve you during the course of the conference.

Welcome to the ICD-10 Summit, SUNNY SINGH
Edifecs President and CEO

As 2012 gets underway, there’s one New Year’s resolution on the minds for healthcare organizations: an effective ICD-10 transition.

The ICD-10 experts at Edifecs have been in the trenches with payers and providers, discussing what’s top of mind for them and how best to navigate ICD-10. Based on those conversations, below are several New Year’s resolutions for effective transition:

1. “I will always keep my executives well-informed.”

There are financial risks, operational risks and relationships risks at stake. Don’t let poor communication make your ICD-10 migration head south. Payers and providers we’ve spoken with say there’s no such thing as over-communication.

2. “I will anticipate and mitigate the risks of a multi-year project.”

Like any multi-year program in a large enterprise, ICD-10 transition comes with risks, such as leadership changes, delayed benefits, and back-loaded project plans. Be aware and plan for these. Never let success of the ICD-10 program rest on the shoulders of one person. We’ve heard payers and providers say, “If so-and-so left, we’d be unable to manage the project.” That’s too great a risk. Organizations must manage ICD-10 as a team. (continued)

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3. “I will learn how to leverage the new ICD-10 data.”

Recognize there is a strategic opportunity hidden in the mandate. The promise of ICD-10 is immense. It will provide a wealth of granular healthcare data that could reveal optimum treatment patterns or uncover ways to reduce the cost of care.

4. “I will implement ICD-10 code assessment and analysis efforts NOW, rather than waiting.”

You don’t have a crystal ball to predict which ICD-10 codes will be billed. You need to identify and begin tracking the ICD codes that will have the greatest impact on your business as soon as possible.

5. “I will find ICD-10 tools to give my organization the greatest insight into how codes are related.”

Look beyond the GEMs. Much like a geographically flat map only shows the distance between two points and not the difficulty of the terrain, GEMs are a great starting point, but they don’t always include all the information you need, such as how and why codes are related and even how they differ. The right tools can help identify the differences in medical concepts between codes—a critical need in avoiding negative impacts to financial neutrality and remediation efforts.

6. “I will ensure my contingency plans cover all dependencies.”

There are numerous areas to consider, such as provider contracting and trading partner readiness. The key is to make sure you test all of them in parallel with remediation.

7. “I will anticipate DRG shift.”

Be able to identify where DRG shift is likely to occur specifically for your organization. You need to know which providers bill those DRGs and which ICD-9 codes are mostly likely to result in DRG shift when billed under ICD-10.

8. “I will begin testing as soon as possible— even if I don’t feel ready.”

Testing is one phase that’s usually compressed. So make sure you do it the right way.
• Filter down all possible ICD-9 test data to just the files that represent the greatest risk to your organization in the migration to ICD-10
• Convert your high-risk ICD-9 test data into ICD-10 equivalent test data
• Develop ICD-10 test files with sufficient variability to fully exercise all processing systems
• Go for it. There is no time like the present to initiate testing

Payers, providers and IT vendors will certainly ring in this New Year with change. If the industry can adhere to these resolutions, ICD-10 could end up a less painful one.

From the Front Lines:
Important Considerations for ICD-10 Implementation

As the transition to ICD-10 starts to pick up steam among healthcare organizations nationwide, Edifecs is working with several customers on their ICD-10 implementations. The Edifecs Client Services team is on the front lines of ICD-10 implementation and is in perfect position to share the best practices that are starting to emerge. Below is a Q&A with members of the team:

1. What are the similarities and differences between HIPAA 5010 and ICD-10 implementation?

HIPAA 5010 affects electronic data interchange (EDI) among payers, providers, clearinghouses and other healthcare organizations. These changes are primarily limited to the format of transactions and ability to receive certain additional fields in these transactions. HIPAA 5010 also allows ICD-10 codes to be sent as part of healthcare transactions.

While several organizations took advantage of HIPAA 5010 to replace their front-end channels with more technologically advanced solutions, the impact of 5010 beyond EDI is limited; therefore, 5010 implementation is typically addressed as a technology project.

On the other hand, ICD-10 has far-reaching impact across a number of processes and divisions within the organization. An ICD-10 implementation project will need to consider the impact to all associated systems, business processes, business models, medical policies, provider contracts, and reimbursement processes.

Such an implementation is a multi-year, multi-department effort requiring a strong program management office (PMO) and a combination of business and technical leads on the project team. It should be executed as a business transformation project, rather than a technology project.

Several tools and technology products exist to facilitate ICD-10 migration, including those that can help mitigate risk, accelerate migration and improve decision making during the project by providing greater access to project information.

2. How does the Edifecs 5010 solution serve as a strong foundation for ICD-10 implementation?

When serving as a foundation for ICD-10, the most important requirements of a 5010 solution is to have built-in data validation, data visibility and a solid tracking system. The 5010 format is a prerequisite for any healthcare organization to receive and send ICD-10 codes in electronic transactions, so a solution like Edifecs 5010 is an ideal precursor to ICD-10.

For example, Edifecs captures all data that enters and leaves an organization and presents it as useful information. This information can be used in many ways during the ICD-10 transformation project: risk analysis, prioritization of high-risk areas, running what-if analyses, creating test data, data de-identification and run-time code translation.

3. What are some of the potential pitfalls to avoid in an ICD-10 implementation?

ICD-10 has far-reaching consequences for an organization, and there can be some significant pitfalls:
• Don’t underestimate the technology solution requirements: There are numerous pieces of literature dedicated to the idea that ICD-10 transformation is a business problem, rather than merely a technology problem. While this is true, the solution eventually will require the right types of technology. Healthcare entities should not make the mistake of ignoring the technology requirements. Healthcare organizations should consider both business and technology aspects during project planning. Technology decisions such as system changes, tool selection and the opportunity to optimize existing systems should be part of the planning and execution phases, alongside business analysis.

Successful ICD-10 testing requires an iterative approach, with ongoing rules adjustment to achieve neutrality.
• Don’t underestimate the testing effort: It’s generally accepted that testing is a significant portion of ICD-10 implementation. One aspect overlooked is the requirement to manage test data, test scenarios and system reset between cycles. Successful ICD-10 testing requires an iterative approach, with ongoing rules adjustment to achieve neutrality. It is imperative that testing teams are well aware of what systems are involved and can then reset factors for each run (factors such as benefit max or accumulators). Generating test data to capture a variety of scenarios and coupling it with risk factors so that high-risk
• Don’t assume a crosswalk will be a quick, stopgap solution: There is no single crosswalk that can cater to the entire organization. So assuming that a comprehensive, all-encompassing crosswalk can be developed as a stopgap solution for ICD-10 remediation is mired with pitfalls that may not become readily apparent until it’s too late. Healthcare organizations also need to understand that implementing a crosswalk solution may still require the same level of investment in impact analysis, risk management, technology and system changes as a full remediation.

• Understand ICD-10 is a multi-year project: Organizations should realize that ICD-10 transformation is a multi-year program. As with all multi-year programs in large enterprises, there are risks involved, such as leadership changes, delayed benefits, back-loaded project plans, etc.

4. How does an end-to-end solution such as Edifecs ICD-10 help define or simplify the implementation strategy? How can it decrease the likelihood of issues during and after implementation?

Since ICD-10 implementation will affect nearly every function in the healthcare value chain, it is very important for any healthcare organization to have an integrated, end-to-end ICD-10 solution. Such a solution encompasses a broad range of needs, such as data analysis to determine financial and operational neutrality, code mapping, and test data management as a part of an integrated strategy. Having separate solutions is not ideal. Integration during each implementation phase of an ICD-10 program is problematic for point solutions. The lack of integration creates many issues in handling ICD-10 changes in systems and business processes. As organizations near their remediation efforts, comprehensive testing will form the basis of successful ICD-10 migration, and—as the saying goes—you can’t test what you don’t know. It’s very difficult to test all unknowns if an end-to-end solution is not driving the ICD-10 implementation strategy.

5. What are the advantages of vendor solutions versus proprietary (in-house) solutions?

• Cost and business interruptions: Vendors typically develop their solutions using thorough analysis of commonly identified problems that most healthcare organizations will face. Vendors conduct extensive consultations with prospective clients and experienced industry consultants. This business expertise, coupled with thorough analysis of possible issues from a holistic program perspective, gives vendor solutions an advantage over in-house solutions. While organizations can create their own in-house solution to meet immediate needs, the longer-term investment is much higher than a vendor solution. Vendor solutions are backed by greater organizational commitment, which provides greater long-term viability of the solution for the client.

• Business transformation, change management: Vendor solutions are designed with a typical product lifecycle in mind, including proper upgrade processes and change management procedures for feature/function updates and incorporation of client-requested improvements. In-house solutions typically don’t have the same level of resource and financial commitments in place to manage upgrade and change management processes over the long term.

• Expertise / experience in building such a solution: Vendors typically rely on highly experienced industry consultants and subject matter experts, along with extensive primary and secondary research to build a solution that would suit the business and technical needs of prospective clients. Though not impossible, it would be incredibly difficult for an in-house team to have that same expertise, especially since they will not have the benefit of going through multiple ICD-10 implementations. The other issue for an in-house team is the possibility of having multiple projects and conflicting priorities.

There is no single crosswalk that can cater to the entire organization...assuming that a comprehensive, all-encompassing crosswalk can be developed as a stopgap solution for ICD-10 remediation is mired with pitfalls that may not become readily apparent until it’s too late.

6. How important is it for an implementation team to have code knowledge and training (certified coders) during and after ICD-10 implementation?

ICD-9 to ICD-10 transformation is a code set version upgrade with widespread ramifications. These codes will be used across the organization. It’s critical for coders to have as much knowledge of medical procedures and anatomy as possible, due to the increased clinical specificity of the new code sets. It all starts with having the right expertise—organizations need coding professionals who have worked with the code sets, understand the hierarchies and know how to navigate the coding structure. Only a coder trained in both ICD-9 and ICD-10 will be able to make informed suggestions that address possible issues during implementation. Coding experts with thorough knowledge of the new code sets and coding guidelines will form the backbone of any successful ICD-10 migration.

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**How Do You Like Your ICD-Tini?**

Whether you prefer it shaken, stirred, or extra dirty, your ICD-Tini will go down more smoothly under the glow of the Florida sunset.

Join your fellow Summit attendees at the opening reception.

• Connect with old friends
• Discover new ones
• Share spectacular conversation
• Succeed in kicking off the Summit in style!

Wednesday, February 15 • 6:00pm-9:00pm • Gazebo Lawn
The Financial Risk of ICD-10 Transition for DRG-Based Reimbursement

For healthcare organizations that depend on DRG (diagnosis-related group) methodology for reimbursement, the transition from ICD-9 to ICD-10 carries significant financial risks. The process of mapping ICD-9 codes to their counterparts in ICD-10 can be very complex, and there is often no single, one-to-one relationship. Therefore, reimbursements could vary dramatically, depending on how DRG groupers are mapped to codes in ICD-10 versus ICD-9.

The Centers for Medicare and Medicaid Services (CMS) uses a DRG structure for Medicare reimbursement to providers called the Medicare Severity Diagnosis Related Group, or MS-DRG. DRGs were developed as a means to classify hospital cases into patient cases with similar conditions that are likely to use the same level of hospital resources.

The DRG for a certain claim is selected based on the ICD code(s) present on the patient claim. Therefore, the reimbursement on every claim depends on the assignment of diagnosis codes and inpatient procedure codes to particular DRGs. As a result, migration to ICD-10 could result in significant over- or underpayment when using DRG-based reimbursement because the code sets that make up the DRG have changed.

Figure 1 shows such an example, where the mapping from ICD-9 to ICD-10 for Diagnosis Code 64111 may result in an underpayment to the provider. This particular code is for “Hemorrhage from placenta previa, delivered, with or without mention of antepartum condition.” In ICD-10, it can be mapped to any of the following codes:

- CMS GEM Diagnosis Code, O4411 – (Placenta previa with hemorrhage, first trimester)
- CMS GEM Diagnosis Code, O4412 – (Placenta previa with hemorrhage, second trimester)
- CMS GEM Diagnosis Code, O4413 – (Placenta previa with hemorrhage, third trimester)

Each mapping carries a certain level of risk. It can be classified as high risk for DRG shift based on the variations in reimbursements created by selecting available ICD-10 Codes for the clinical scenario, and then processing them through the ICD-10 Grouper.

Figures 2 and 3 show examples of a no-risk and a moderate-risk scenario created by CMS GEMs. All entities that interact with the Medicare Inpatient Prospective Payment System must assess the financial risk created by such mappings.

Based on the above examples, it’s easy to draw a significant conclusion: For health plans, it’s imperative that they identify and work with high-risk providers—that most likely to use codes at high risk for reimbursement variances—to alleviate risks in DRG-based reimbursements. In order to remediate for the risks associated with DRG-based reimbursement, health plans will need to assess their ICD-9 to ICD-10 maps, create claim scenarios in ICD-10 from these maps based on historical claims, process the scenarios against the ICD-10 groupers and identify ICD-10 codes that drive DRG shift.

Once the at-risk code relationships and scenarios are identified, health plans may either independently code the scenarios in ICD-10 based on the clinical notes (to confirm whether the mapping experience is predictive of clinical experience), or ask the provider community to code the specific scenarios in ICD-10. Once both the health plan and provider agree on which scenarios will have DRG shift in ICD-10, they can address the corresponding expected change in payments through contractual approaches, such as updating relative weights assigned to specific DRGs processed in ICD-10, or using a post-implementation reconciliation model.

For example, when reviewing a midsize healthcare plan’s data, Edifecs determined that approximately 83% of the MS-DRG-based ICD-9 claims led to the same MS-DRG-based grouper when translated via GEMS to the ICD-10 claim scenarios. The claims in this 83% would be considered low risk and prioritized accordingly.

However, 15% of the plan’s MS-DRG-based ICD-9 claims translated to claim scenarios in ICD-10 led to either a DRG shift for all mapping scenarios (high risk) or a DRG shift for a subset of scenarios (moderate risk). The remaining 2% of the transactions in ICD-9 were not group-able and required research before mapping into ICD-10.

The scope of identifying and implementing mitigation strategies for DRG shifts can be daunting for health plans with a huge provider network. The ideal approach will focus efforts on those providers that send claims containing DRGs that pose the greatest risk to financials. This can be done by modeling historical claims into ICD-10 claim scenarios for grouper analysis and identifying the grouper shifts that occur and corresponding delta in payments.

In the above example, this would be equivalent to identifying the specific providers that send all or most of the 15% high- and moderate-risk ICD-9
Changing the Game: Mandates and ACA Create Opportunity for Enhanced Payer-Provider Collaborative Models

Regardless of political leaning or personal opinions, most healthcare professionals recognize that federal mandates, regulations, and the Affordable Care Act will dramatically change the way we measure, deliver and finance healthcare. From patient engagement to financial settlement of charges, the way the “game is played” is about to change—in a big way.

While these changes have the potential to be disruptive, there’s also a real opportunity to rein in runaway healthcare costs staggering the US economy by effectively leveraging the information that will become more accessible as a result.

What is (or will be) driving this accessibility? Three things stand out to me, in particular:

1. The timing and incentives tied to recent mandates and the ACA
2. A greater ability and willingness among healthcare organizations to share information
3. Broader adoption of technologies that will enable collaboration

Each of these is discussed more fully below:

1. Timing and Incentives of Mandates and the ACA

Both are architecturally significant, in that they drive greater interoperability within the healthcare community. The initial step that laid the foundation was the publication of Meaningful Use regulations, along with their incentive provisions. In response, most healthcare providers accelerated adoption of electronic medical record technology—a huge sea change for this segment, which has traditionally been buried in paper.

By incenting providers to adopt the “electronic habit,” the government has prodded them into recording clinical observations, events, tests, treatments and medications in formats easily shared with others.

While it’s certainly a benefit to share information among providers treating a given patient, the most important benefit is that this information can now be shared with—and measured by—partners and government agencies that pay for care delivery.

2. A greater ability and willingness among healthcare organizations to share information

The ease of sharing electronic records creates an entirely new paradigm for healthcare. Even traditionally resistant organizations will begin to break down long-standing barriers in the areas of setting goals, aligning incentives and sharing information. Capturing, sharing and measuring data is an incredibly powerful tool for improving individual and population health outcomes.

For example, when a patient (we’ll call him “Herb”) visits his doctor, has a test and receives a prescription, here are several benefits tied to sharing information:

- Other physicians, hospitals and laboratories that participate in Herb’s care could access that information and avoid ordering the same test
- They could also alert Herb’s doctor to any medication interaction problems for a drug Herb is already taking
- Herb’s health plan could share his claim data with the Accountable Care Organization (ACO) responsible for helping Herb manage his own care and coordinating his care among the ACO provider community

The last example is particularly important if Herb obtains medical services outside the ACO community. His medical information will still be available to the ACO providers, giving a more complete picture of medical products and services Herb is receiving.

Financial models that incent ACOs to coordinate care, reduce unnecessary services and improve measurable health outcomes aren’t just enabled by the new laws and regulations; they’re mandated for CMS-covered beneficiaries.

As these provider-based, patient-focused organizations emerge, commercial payers are rapidly adopting collaboration models that drive better coordination among providers—not only aligning the incentives appropriately to drive better behavior, but providing the means to manage and measure the models’ effectiveness.

3. Broader adoption of technologies that will enable collaboration

Technology will be a key enabler of this emerging collaboration for organizations competing in this new environment. Providers and payers will have to adopt new technologies, such as:

• Health Information Exchange platforms
• New data repository models that combine clinical and administrative (claim) data
• Care coordination and management applications (particularly for ACOs incented to collaborate more efficiently)
• Business intelligence tools that provide dashboards for measuring program effectiveness and individual care plan compliance with best practices or program guidelines

So what’s the conclusion we can draw from all of the above? Our industry is in a state of flux, brought about in large part by federal mandates and the advent of ACOs. The game—and the rules we must all follow—has changed.

There’s an opportunity that’s risen from increased adoption of electronic formats, greater information sharing, and introduction of technologies that can make both of those efforts easier and less expensive. The end-game, however, is where the real benefit lies: Improving health outcomes for the people who depend on the healthcare community for financing and delivery of their medical care.

Best wishes,
RYAN MCDERMIT
Senior Director of Product Management
Edifecs
SUMMIT AGENDA

Unless otherwise noted, all activities will take place in the Rosen Ballroom

WEDNESDAY, FEBRUARY 15

3:00 – 6:00 pm Registration – Hotel Main Lobby
6:00 pm Welcome & Networking Reception – Gazebo Lawn

THURSDAY, FEBRUARY 16

7:00 – 8:00 am Breakfast – Calusa Room
7:00 am – 10:00 am Registration – Rosen Ballroom Foyer
7:00 – 10:00 am Registration – Hotel Main Lobby
7:00 – 8:00 am Networking Lounge Open – Grandville Ballroom
8:00 Welcome & Summit Overview
Sunny Singh, CEO, Edifecs
Herb Larsen, Principal - Healthcare Industry Strategy, Edifecs
8:15 am How to Shift From “Eeyore” to “Pollyanna” on Your ICD-10 Project
Christina Lucero, Principal Research Analyst - Healthcare, Gartner
Do you cringe when you hear the word “ICD-10”? You don’t have to. In this session, learn how to change your perspective of ICD-10 by taking an in-depth look at people, process, and technology, and begin to view this as an opportunity to become the “best in class.” Christina Lucero will share her insights into what’s trending in ICD-10 and how you can become a champion.

9:15 am ICD-10, Neutrality & Testing: A Look at BCBSM’s ICD-10 Program
Dennis Winkler, Technical Program Director of Program Management and ICD-10, Blue Cross Blue Shield of Michigan
Neutrality is a hot topic within ICD-10. However, it can be a struggle to define the dimensions of neutrality, predict outcomes, or even figure out how payers and providers can work together to achieve their neutrality objectives. This session defines six dimensions of neutrality and examines Blue Cross Blue Shield of Michigan’s approach to achieving payment neutrality.

10:15 am Break

10:45 am Sneak Preview: Results from IDC Health Insights’ ICD-10 Testing Survey
Janice Young, Research Director - Payer IT Strategies, IDC Health Insights
Testing will be a major focus of ICD-10 activity for the next two years, and many questions about it remain unanswered: What types of testing will be most difficult? Which systems and processes represent the greatest risk? IDC Health Insights conducted an extensive survey of business managers, project managers and quality assurance staff to assess the status, plans, risks and alignment for ICD-10 testing. This session will provide a preview of the survey results, which will be publicly released after the Summit.

11:45 am Lunch – Tarpon Terrace

12:30 – 1:30 pm Moderated Table Topic Discussions
Steven Benjamin, Program Director, ICD-10, UnitedHealthcare
David Biel MCS, Principal, Deloitte
Don Fowler, Vice President, BlueCross BlueShield of North Carolina
Alan Gabriola, Health Plan Director, Deloitte
Ross Lippincott, Vice President – 5010 and ICD-10 Programs, UnitedHealthcare
Christina Lucero, Principal Research Analyst, Gartner
Ryan McDermitt, Sr. Director – Product Management, Edifecs
Dr. Joe Nichols, Principal, Health Data Consulting
Cindy Troxler, VP – Claim Operations, BlueCross BlueShield of North Carolina
Kristine Weinberger, Sr. Healthcare Business Consultant, Edifecs
As you continue to develop your ICD-10 strategy, you have plenty of resources here at the Summit! Sharing information, brainstorming solutions and problem solving in real time is one reason why you’re here. In this session, you will engage in small-group discussions to dissect the ICD-10 challenges you and your peers have voted most pressing, and then develop a working plan of action within an interactive, moderated environment.

1:30 pm Report Out: Table Topic Discussion Results
Each table will share their challenges, discussion points, ideas and plans of action with the other Summit attendees.

2:30 pm Break

3:00 – 4:00 pm Accelerating your ICD-10 Migration through Strong Payer-Provider Collaboration
Lyman Sornberger, Executive Director, Revenue Cycle Management, Cleveland Clinic
Annette Melda, ICD-10 Program Manager, Medical Mutual of Ohio
The best path to ICD-10 migration involves strong cooperation between the provider and payer. In this session, you’ll hear how Cleveland Clinic partnered with Medical Mutual of Ohio to accelerate its transition to ICD-10, including the lessons they learned along the way. You’ll gain insight into what it takes to collaborate effectively across organizational boundaries.

4:00 – 5:30 pm Panel Discussion: We’re All in this Together
Moderator:
Dennis Winkler, Technical Program Director of Program Management and ICD-10, Blue Cross Blue Shield of Michigan
Panel:
Patrick Murta, Enterprise Architect, Humana
Gail Hicks, Director, HIPAA & ICD-10 Program Office, BlueCross BlueShield of North Carolina
Lyman Sornberger, Executive Director, Revenue Cycle Management, Cleveland Clinic
Kristine Weinberger, Sr. Healthcare Business Consultant, Edifecs
ICD-10 will affect nearly every participant in the healthcare ecosystem. This highly interactive panel discussion features ICD-10 experts from payer, provider and vendor organizations. Panelists will discuss current challenges and lessons learned on their ICD-10 projects, provide insights into future opportunities, and share considerations for optimizing project success. Topics will include governance, financing, project management, architecture, payer-provider relations and many others.

5:30 pm Rest & Relaxation

6:30 pm Cocktail Reception – Tarpon Terrace

7:30 pm Dinner & Charitable Cause Activity
FRIDAY, FEBRUARY 17

7:00 – 8:00 am  Breakfast – Calusa Room
7:00 – 9:00 am  Networking Lounge Open – Grandville Ballroom

8:00 am  Managing the ICD-10 Transformation Across Your Enterprise
Alan Gabriola, Health Plan Director, Deloitte LLP
Scott Hightower, Director of e-Health, Blue Cross and Blue Shield of Tennessee

“All we have to do is extend the field length…right?” Ensuring compliance with the CMS mandate for ICD-10 by October 1, 2013 spans the enterprise. It has the potential to impact strategy, people, process and technology. At its core, ICD-10 will enhance our industry language by introducing additional intelligence, resulting in both industry-wide challenges and opportunities. Blue Cross and Blue Shield of Tennessee and Deloitte share perspectives on ICD-10 enterprise transformation.

9:00 am  Real-world Perspectives on ICD-10 Testing
Testing for ICD-10 will present some unique challenges for healthcare organizations. Learn from Humana and WellPoint as they explain how they are planning to complete the massive ICD-10 testing efforts required for their respective organizations. Sid Hebert from Humana will discuss his approach to internal testing, while Florentino Buendia and Michael Fierro from WellPoint will cover the external testing challenge.
Florentino Buendia, Provider Contract Director, WellPoint
Michael Fierro, Director, External Partner Readiness & Advocacy, WellPoint
Sid Hebert, ICD-10 Program Manager, Humana

10:00 am  Break

10:30 am  Best Practices in Remediating Medical Policies for ICD-10
Joe Nichols, MD, Principal, Health Data Consulting LLC

ICD-10 remediation will require extensive work across the enterprise, affecting both clinical and business operations. In this session, Dr. Joe Nichols will review best practices in remediating existing policies and rules that use ICD-9 in current processing or categorization logic. He will also discuss medical policy remediation approaches that effectively leverage the advantages of ICD-10.

11:30 am  The Road Ahead: Outlook from CMS
Christi Bordeaux Dant MPM, U.S. Department of Health & Human Services, Centers for Medicare and Medicaid Services, Office of E-Health Standards & Services

ICD-10 is a massive change that offers the promise of bringing the US healthcare system to a higher standard of care. In this presentation, Christi Dant will share how CMS—and the industry overall—is progressing against the October 2013 deadline, as well as the benefits expected from ICD-10 on a national and global scale. Dant will also highlight how ICD-10 will converge with other mandates to deliver a more precise measurement of care and cost.

12:30  Grab-and-Go Box Lunch & Adjourn
Herb Larsen, Principal - Healthcare Industry Strategy, Edifecs
I CD-10 Summit Speaker Biographies

Florentino Buendia  
WellPoint, Inc.

Florentino Buendia serves as Provider Contract Director at WellPoint. In this role, he is responsible for leading provider contracting and analytical activities surrounding the transition to ICD-10. Buendia has spent 16 years in health insurance in the areas of product development, project management, provider auditing and provider reimbursement. His experience includes serving in several management roles within provider reimbursement and auditing. Buendia earned a BS in Business from Miami University of Ohio and an MBA from Xavier University.

Christi Bordeaux Dant, MPM  
Centers for Medicare & Medicaid Services

Christi Dant currently serves in the Office of E-Health Standards & Services, the authoring entity of the ICD-10 rule, at the Centers for Medicare and Medicaid Services. She was recently named leader for the HHS enterprise-wide implementation effort, under the auspices of the Office of the Chief Information Officer at HHS.

Dant entered federal service as a Presidential Management Fellow in 1999 and has since served in a variety of capacities in the federal government at HHS, FEMA, and the Social Security Administration.

Michael Fierro  
WellPoint, Inc.

Michael Fierro is the Director for External Partner/Subsidiary Readiness & Advocacy at WellPoint and is responsible for tracking the preparedness of WellPoint’s external partners and vendors. He also leads advocacy for the ICD-10 initiative and liaises with BCBSA, AHP and CMS. Fierro began his career at the California Department of Health Services, where he worked on cancer prevention, tobacco and nutrition issues. From there, he progressed through a series of increasingly responsible healthcare-related roles at the National Governors Association, the New Mexico Department of Health, and Deloitte Consulting before joining WellPoint in July 2010. Fierro has published numerous papers on public health and health policy. He earned a bachelor’s degree in Psychology from California State University Sacramento.

Alan Gabriola  
Deloitte LLP

Alan Gabriola is a Health Plan Director in Deloitte’s Life Sciences & Healthcare industry practice. He has 20 years of experience in providing engagement delivery leadership, including efforts around enterprise transformation, mergers and acquisitions, and technology strategy and architecture.

Gabriola has led numerous multi-discipline programs, spanning the entire spectrum of tactical and large-scale strategic global programs. He has extensive experience in collaborating with functional and technical teams to deliver effectively on complex cross-functional initiatives.

Sidney Hebert  
Humana, Inc.

Sidney Hebert is the ICD 10 Program Manager at Humana. In this role, he is responsible for HIPAA transaction and code set enforcement, ICD 10 business transformation and mitigations, and ICD 10 compliance for acquired and joint venture businesses.

Hebert joined Humana in 2009 to focus exclusively on ICD 10 migration, and brings 30 years of experience in large-scale system integration and business operations to the challenging ICD-10 transition.

Prior to joining Humana, Hebert worked with two Fortune 50 companies, delivering large-scale automation technology programs for automotive and white goods manufacturing. He also managed technology operations for a Fortune 500 payroll services company. Hebert holds an undergraduate degree in Electrical Engineering.

Gail Hicks  
Blue Cross Blue Shield of North Carolina

Gail Hicks is the Director of Blue Cross Blue Shield of North Carolina’s HIPAA Program Office. She has worked in the healthcare industry for 30 years, focusing mainly in the areas of Managed Care Systems and Operations. As the HIPAA Program Director, she led the implementations of the 4010 and 5010 HIPAA transactions and the National Provider Identifier. Currently, she is responsible for leading the ICD-10 implementation efforts. Hicks also co-chairs the North Carolina Healthcare Information and Communications Alliance (NCHICA) ICD-10 Taskforce.

Scott Hightower  
Blue Cross Blue Shield of Tennessee

Scott Hightower joined Blue Cross Blue Shield of Tennessee (BCBST) in December 2010 as its Director of e-Health. His primary responsibility in this role is to provide leadership for the many layers of the ICD-10 program at BCBST. Additionally, he is responsible for developing and promoting the use of EMRs throughout the Tennessee Provider community.

Hightower worked for Blue Cross Blue Shield of Florida from 1986 to 2010, where he held several key positions including Network Management Director, Director of Provider Connectivity and Director of Electronic Transaction Management. He graduated from the University of Alabama at Huntsville in 1975 with a BA degree in Political Science.

Annette Melda  
Medical Mutual of Ohio

Annette Melda is the ICD-10 Program Manager at Medical Mutual of Ohio. In this role, she works very closely with the Vice President of Strategic Initiatives, and together they are accountable for the implementation of ICD-10 across all business and IT areas at Medical Mutual. Melda is a proven business and information technology leader with more than 15 years of experience managing projects in the health insurance industry. She has been with Medical Mutual for 25 years and has served in a variety finance and IT roles.

Patrick Murta  
Humana, Inc.

Patrick Murta is an Enterprise Architect at Humana, where he is responsible for the company’s ICD-10 enterprise architecture including tools, remediation approaches, and code distribution and services. He is also responsible for enterprise HIPAA and clinical HL7 infrastructure architecture and enterprise business-rules management system architecture.

In addition to work on the ICD-10 implementation, Murta has a patent in process for developing a business-rules architecture for dynamic clinical evaluation and intervention routing.

Joe Nichols, MD  
Health Data Consulting LLC

Joe Nichols, MD, is the Principal of Health Data Consulting LLC. He has 35 years of in-depth healthcare experience in the provider, payer and information technology markets, with a focus on healthcare data, standards and information system application of business requirements.

Nichols is a certified ICD-10 coding trainer, and his primary focus has been on ICD-10 and the implications for a variety of business entities.

Prior to joining Gartner, Lucero was a program manager at WellPoint, where she was responsible for project execution in Senior Products (Medicare/Medicaid) and various mandates including ICD-10. She has worked closely with vendor management throughout her career. Lucero also has a background in corporate training and technical writing. She spent the early part of her career in the nonprofit and government sectors, where she became familiar with regulatory and compliance issues.

Christina Lucero  
Gartner

Christina Lucero is a Principal Research Analyst in the Gartner Industries Research group, with responsibility for healthcare payer research. Areas of coverage include healthcare core administration platforms, fraud and abuse, product configuration, and ICD-10.

Lucero has more than 20 years of experience in the IT industry, 15 years in project management and nearly a decade of healthcare experience. She has served in various IT industry roles, including IT infrastructure and data center management.

Christi Dant  
Medical Mutual of Ohio

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Lyman Sornberger  
*Cleveland Clinic Health System*

Lyman Sornberger joined Cleveland Clinic Health Systems (CCHS) in 2006 and currently serves as its Executive Director of Revenue Cycle Management. Prior to his affiliation with CCHS, he was with the University of Pittsburgh Medical Center (UPMC) for 22 years as a leader for its revenue cycle management efforts.

Sornberger’s role at CCHS comprises Revenue Cycle Management for all 11 hospitals in the Cleveland Clinic Health System for Ohio and Florida, and 1,800 foundation physicians. His responsibilities include all CCHS patient access services, health information management, and billing.

Dennis Winkler  
*Blue Cross Blue Shield of Michigan*

Dennis Winkler is the Technical Program Director of Program Management and ICD-10 at Blue Cross Blue Shield of Michigan (BCBSM). He is responsible for ICD-10 program direction and is the IT business partner for Medicare Advantage.

Winkler graduated with distinction from the University of Michigan’s Ross School of Business. He spent the first 11 years of his career with Anderson Consulting (now Accenture), specializing in large, complex, system development projects. Winkler joined BCBSM in 1998 and has since been responsible for leading major enterprise programs, including HIPAA 4010 implementation, Social Security Number elimination and the National Provider Identifier initiative. He has spoken at several national summits and seminars about ICD-10 since BCBSM began its ICD-10 implementation.

Janice W. Young  
*IDC Health Insights*

Janice W. Young is Research Director for Payer IT Strategies at IDC Health Insights. In this role, Young is charged with identifying the key emerging trends and technologies impacting payer business success and IT portfolio management today. Her research focuses on future healthcare business and IT scenarios, healthcare reform impact on business and technology investment, new trends and technology for operational and transaction efficiency, accountable care organizations, health insurance exchanges, partnership/outsourcing trends, care and clinical management strategies and technologies, actionable advice/advanced analytics and communications strategies.

Prior to joining Health Industry Insights, Young spent eight years as Vice President and Research Area Director for Gartner Research Advisory Services, where she led research strategy for the company’s healthcare payer market initiatives. Young holds a Bachelor of Science (BS) degree and a Master of Health Sciences, Health Finance and Management from Johns Hopkins University.

**Attendee Demographics**

The attendee list for the ICD-10 Summit boasts a wide range of healthcare professionals from across the industry. Together, the group of attendees represents more than 50 organizations, and each individual is actively involved in his or her organization’s ICD-10 initiative.

**Attendee Organizations**

- Health Provider: 25%
- Commercial Payer: 25%
- Government (State/Federal): 9%
- Clearinghouse: 6%
- Other: 17%
- Blue Plan: 18%

**Current ICD-10 Implementation Status**

- Planning: 36%
- Development: 49%
- Implementation: 15%
- Testing: 5%

**Attendee Roles**

- ICD-10 Lead/Program Management: 47%
- IT Management: 11%
- Other: 14%
- Managed Care: 11%
- Medical Management: 1%
- Revenue Cycle Management: 5%
- Claims: 3%
- Benefits/Medical Policy: 1%
- EDI: 1%
- Finance: 2%
- Application Development/QA/Testing: 3%

**Attendee Demographics**

- Connect with ICD-10 experts
- Meet others who share your challenges
- Enjoy a snack or check in with your office back home

**Expert Connect in the Networking Lounge**

**Meet that “Special Someone”**

You know who we’re talking about. The industry expert with answers to your ICD-10 questions. Or the fellow attendee with an interesting take on the news of the day. The Lounge is a perfect place to:

- Connect with ICD-10 experts
- Meet others who share your challenges
- Enjoy a snack or check in with your office back home

**THURSDAY, FEBRUARY 16**

7:00am – 5:00pm, Grandville Ballroom  
*Expert Connect (7:00-8:00am)*

**FRIDAY, FEBRUARY 17**

7:00am – 9:00am, Grandville Ballroom  
*Expert Connect (7:00-8:00am)*

12:30pm – 2:00pm, Calusa Room  
*Expert Connect (12:30-2:00pm)*

To schedule an Expert Connect 1:1 Consulting Session, contact Jennifer Ring-Perez:  
Jennifer.ring-perez@edifecs.com / 206.619.8244
My ICD-10 Project Will Go Exactly As Planned...(But what if it doesn’t?)

Many healthcare organizations planned early and are expecting to be completely ready for the upcoming transition to ICD-10. However, a widely acknowledged fact is that when October 2013 rolls around, many other healthcare organizations will find they haven’t been able to remediate all of their systems completely.

The financial stakes are very high. For a project of the magnitude and pervasiveness of ICD-10, a contingency plan is a critical component of a well-devised risk management strategy.

So how can healthcare organizations devise contingency plans that will protect them from non-compliance? Some health plans are beginning to explore a strategy referred to as a Step-Up / Step-Down (SUSD) approach. The base assumption in this concept is that by October 2013, a health plan may not have been able to remediate all of its system components to accept ICD-10-coded transactions. As the health plan starts receiving ICD-10-coded transactions from providers after the deadline, the ICD-10 codes in these transactions would be “stepped-down” to ICD-9 before being passed along to the un-remediated system for processing. When the ICD code is required for the outbound transaction, the original submitted code (that has been retained) would be reattached before it is sent out to the provider or trading partner.

Considerations in Adopting a SUSD Approach

A short-term SUSD strategy could be a good risk mitigation option against potential ICD-10 project delays. It’s also a choice for systems or components of systems that will be replaced fairly soon and therefore, not worth the effort and cost it would take to remediate them. In evaluating SUSD options, healthcare organizations need to ensure their approach fully satisfies the following three requirements:

1. Payment Neutrality
2. Auto-Adjudication Rates
3. Transparency

1. Payment Neutrality

Financial neutrality is one of the primary goals of most health plans. Any SUSD approach will receive and transform an inbound transaction (e.g., ICD-10 to ICD-9). However, a well-designed SUSD solution will also allow comparison of (MS-DRG) groupers that must be obtained with an ICD-10 claim with those obtained from the transformed (ICD-9) claim. Health plans can minimize the risk of overpayment or underpayment by comparing the two groupers. If these groupers match, then the claim may be processed as usual. If the groupers don’t match, the claim may be pended for manual intervention.

2. Auto-Adjudication Rates

If claims-processing systems are not able to handle ICD-10 in some way by the October 2013 deadline, the result will be an increase in the number of claims that must be manually adjudicated. This could delay payments, reduce provider satisfaction and eventually affect the health plan’s compliance with its service level agreements, as well as its bottom line.

Any SUSD solution must be able to handle the potentially complex logic required to convert a transaction from ICD-10 to ICD-9 and vice versa. The ability to transform claims accurately will minimize the adverse impact on auto-adjudication rates and the health plan’s bottom line.

3. Transparency

If a transformation (step up or step down between code sets) is performed, then the decisions used to arrive at that transformation (which are then used to process payments to providers) must be published and available to providers. This is not merely optional; the Sarbanes-Oxley Act of 2002 requires senior officers of a company to institute adequate internal controls for ensuring the accuracy of financial reports and disclosures.

Transparency of the SUSD solution not only enables ongoing visibility to trading partners, it also provides an audit trail for all inbound and outbound transactions, thereby allowing the health plan to reliably maintain this information.

Conclusion

Most healthcare organizations will need to devise contingency plans in case their ICD-10 projects don’t proceed as planned. It’s also likely that many will have to reduce the number of systems that can (or should) be remediated prior to October 2013—which exposes the organization to non-compliance.

While SUSD is clearly not a silver bullet, it does provide short-term relief from delayed projects and could serve as a temporary measure for systems soon to be retired. As such, healthcare organizations should be evaluating SUSD at least as part of their risk mitigation strategy. To do anything less would be imprudent and could prove to be a fatal flaw in what would otherwise be a solid ICD-10 transition project.

Best wishes,
RYAN MCDERMITT
Senior Director of Product Management
Edifecs

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Along the ICD-10 Testing Path:
The Strategic Imperative of Business Readiness Testing

One of the key focus areas for industry leaders and workgroups already involved in ICD-10 transition is defining the requirements for testing scope and approach. Ultimately, the goal of testing and test analysis is always to ensure the highest quality implementation, with as few defects as possible.

In the case of ICD-10, “defects” takes on a broader definition. It’s not enough to ensure file formats are correct (as was the case with HIPAA 5010.) ICD-10 has the potential to adversely affect business performance, if not handled correctly. The goal of ICD-10 testing, therefore, is to ensure “net neutrality”—that is, not only minimizing disruptions to cost, revenue and business operations after the cutover date, but also ensuring that all measured results and business outcomes before and after the cutover date are equivalent to the greatest extent possible.

Because ICD codes are intrinsic to the design of benefits, medical policies, disease management programs, claims adjudication, and payments, health plans must test all of these systems to ensure business results (e.g., payments or auto-adjudication rates) remain consistent in the conversion from ICD-9 to ICD-10.

To be successful in the ICD-10 transition, organizations will need to adopt a strategic approach, including business readiness testing.

The challenge with business readiness testing is that individuals with a deep understanding of business rules and processes are essential—even though they can barely afford to spend the months ICD-10 testing may take. They also don’t usually have the business experts don’t usually have the technical skills required for using testing tools.

To test business readiness for ICD-10 successfully, health plans need to close the gap between business knowledge and testing system expertise across several different processes—each of which may require different business experts.

We have broken down business readiness testing into four major components that organizations should include in their testing plans:

1) Financial Neutrality – Keeping Payments Equivalent from ICD-9 to ICD-10

Financial neutrality is the result of achieving payment neutrality across the vast majority of claims. Business experts have the expertise to evaluate whether each claim was paid correctly and to review which ICD-10 codes were used to validate the conversion logic. A few examples of financial items to test include:

- DRG payment variation between ICD-9 and ICD-10
- Non-DRG payment variation between ICD-9 and ICD-10 (e.g., fee-for-service or per diem)
- Financial categorization consistency in actuarial applications between ICD-9 and ICD-10
- Allowed amount variations in amounts received from re-pricers
- Aggregate allowed amount variations between ICD-9 and ICD-10
- Member liability amount (associated with denials of service)
- Variations between ICD-9 and ICD-10

2) Operational Neutrality – Ensuring automated processing levels remain consistent

The transition to ICD-10 means the business rules and logic that govern the rules for automated processing of enrollment, claims and payments need to be rewritten. Otherwise, automated processing levels can drop, increasing the need for manual intervention and causing processing delays. To ensure operational neutrality through the ICD-10 transition, business experts will need to review claim editing to ensure claims continue to process automatically under ICD-10 as they did with ICD-9. Other examples of operational processes business experts must analyze for neutrality, or equivalent levels of automation, include:

- Prompt payment penalty analysis
- Contracted SLAs and associated financial penalty analysis
- Impact of ICD-10 codes on paper claims processing
- Trend analysis consistency for reporting (e.g., HEDIS measures, employer group trends, etc.)

3) Benefit Parity – Confirming members’ benefits remain the same

Many benefit plans define coverage in terms of the ICD-9 codes (or range of codes) they will and will not pay. Business experts will need to understand, evaluate, and approve how these codes are aligned in ICD-10 to ensure the benefit design still adheres to the contract between the health plan and the group, and that each member’s continuity of care isn’t disrupted. Once the health plan adjusts the codes in the various benefit plans, business experts will need to verify implementation of these changes in several areas.

4) Medical Policy Parity – Making sure treatment protocols don’t inadvertently change

Almost all health plans translate medical policies for treatment into procedure and diagnosis codes, including ICD-9, which they then use during the claims adjudication process. Business experts and the medical director will all need to review the outcome of medical policy testing to determine if the integrity of the medical policy is upheld during the testing process—and they will then need to sign off on these test cases. Examples of medical policy testing include the following:

- Medical necessity edits
- Prior authorizations
- Utilization review

The Significant Challenges for Business Readiness Testing

While we’ve listed each business readiness testing area separately, it’s important to construct tests that span them all. An effective approach must address several formidable challenges and should include business users who will help determine the success or failure of ICD-10 testing. Their ability to identify potential risks to achieving financial and operational neutrality, as well as benefit and medical policy parity, through the transition will be crucial.
Solving an ICD-10 Coding Challenge:

How Business Rules can Improve Coding Accuracy and Enable Reliable Reimbursement

One of the promises of ICD-10 (and a core objective of the mandate) is the potential for enhanced granularity, laterality and overall reporting accuracy. This is important because health plans base their reimbursement to providers on the medical condition of the patient and the appropriate procedure used for treatment. The enhanced clarity within ICD-10 codes is intended to help health plans reliably reimburse providers by ensuring correct reporting of patient diagnoses and the corresponding treatment.

However, the transition from ICD-9 to ICD-10 creates risks within this mapping process. There is often no single, one-to-one relationship between ICD-9 and ICD-10 codes, so an ICD-9 procedure code often no single, one-to-one relationship between ICD-9 and ICD-10 codes, which could generate varying payment amounts.

Below is an example that demonstrates the importance of ICD-10 codes for ensuring accurate payments.

**Figure 1** shows a claim coded in ICD-9 that will be translated to ICD-10 before adjudication. The claim reports an injury to the thoracic aorta (ICD-9 code 901.0), which was treated using a “suture of the artery” (ICD-9 code 39.31). This procedure (39.31) alone can translate to 300 possible ICD-10 codes, corresponding to the various surgical approaches and possibilities for artery repair throughout the body.

Without a perfect solution to the problem of translating from ICD-9 to ICD-10, business rules can help health plans to get closer to financial neutrality.

Suture of the artery (ICD-9 code 39.31) can map to three ICD-10 procedure codes (ICD-10 codes 02QW0ZZ, 02QW3ZZ, and 02QW4ZZ), which correspond to different approaches to the procedure: open, percutaneous or percutaneous-endoscopic.

These approaches are very different and may justify different payment amounts. A standard one-to-one mapping cannot be chosen in this scenario because more information is needed beyond the ICD-9 code (39.31) and claim modifiers to accurately determine which approach was used in the procedure.

The ideal approach to this problem is to use business rules to extract relevant information about the procedure from the healthcare claim, and then translate to the correct ICD-10 code. This approach circumvents the limited information provided in the ICD-9 code and claim modifiers.

In the above scenario, the diagnosis points to an injured thoracic aorta, which narrows the corresponding procedure options to three possible ICD-10 codes. Using a business rule, information about “length of stay” can be extracted from the claim and used to estimate which surgical entry/approach was used.

A longer stay (over 2 weeks) suggests an open approach, whereas a short stay (under 7 days) suggests that the approach was percutaneous. This intelligent mapping of the ICD-9 codes to ICD-10 would reflect the correct diagnosis and procedure, therefore helping establish medical necessity and resulting in the correct payment for that approach.

To leverage business rules for ensuring accurate reimbursement, health plans will need to first identify and prioritize their high-risk code mappings, implement the appropriate business rules to ensure accurate translation and then configure their translation system to apply them as necessary. Without a perfect solution to the problem of translating from ICD-9 to ICD-10, business rules can help health plans to get closer to financial neutrality.**